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# Perceptions of the transition to assisted living as a function of psychological well-being, instrumental activities of daily living, and coping: A prospective study

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# PERCEPTIONS OF THE TRANSITION TO ASSISTED LIVING AS A FUNCTION OF PSYCHOLOGICAL WELL-BEING, INSTRUMENTAL ACTIVITIES OF DAILY LIVING, AND COPING: A PROSPECTIVE STUDY

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A Thesis

Presented to the Faculty

of California State University,

San Bernardino

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In Partial Fulfillment

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by

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ABSTRACT

Assisted living facilities have seen a boom in the retirement industry within the past decade and have multiplied in just the last few years at a 15-20% increase per year (American Association of Retired Persons, 1999). Little research has looked at elders' perceptions of moving to assisted living from their independent living domains, specifically within continuing care retirement communities (CCRCs). Past gerontological research shows this transition is resisted by CCRC residents. In the present study, a survey was sent to a sample of residents (over 62 years old) from six campuses in a nationwide retirement community in the United States. There were 301 participants: 105 males, 188 women, and eight declining to specify gender.

This study examined the influence of three predictor variables on perceptions of assisted living: psychological well-being, functional status, and coping strategies. A multiple regression analysis was used to examine the influence of these factors on perceptions of the transition to assisted living. Elders who had lower functional ability had less positive feelings toward their assisted living facility ($R = -.123$, $p < .05$). Residents who showed

emotion-oriented coping strategies had a negative view of assisted living ($R = -.163$, $p < .01$). All six dimensions of psychological well-being were highly correlated with positive perceptions of AL ($R$ between .196 and .388, $p<.01$ for all subscales).

It is hoped this study will contribute information to a small but growing literature on a residential transition within a CCRC that currently involves a relatively small number of the elderly, but is certain to become more common in the future.

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# CHAPTER ONE

## INTRODUCTION

More than 70% of the population in the United States lives to age 65, and the overall life expectancy is now approximately 76 years. It is estimated that 5.2% of the elderly live in some form of nursing or retirement home (Rowe & Cahn, 1998). In 1963, congregate housing surfaced as a combination of communal living and service for low-income seniors (Pruchno & Rose, 2000). Based in part on these congregate living models, continuing care retirement communities (CCRCs) have emerged as residential options for a growing number of mostly affluent retirees. Consistent with their mission of continuing care, CCRCs offer a continuum of residency options, from independent living to nursing home care. In the last two decades, assisted living (AL) facilities have emerged as the intermediate structure between the independent living (IL) and the nursing home levels of care. The number of AL facilities in this country grew exponentially throughout the 1990's (Pruchno et al., 2000). Today, AL facilities are becoming better equipped to meet the physical, cognitive, and psychological needs of frail elderly. The assisted living

facility's purpose in the continuum of care is to maximize and preserve residents' autonomy while providing adequate structural and medical support in the transition to nursing home care.

## Reasons for Study

The frail elderly might be described as those whose lifespan has exceeded their health span. Among community dwelling elders, increasing frailty typically results in a transition from home to nursing home. Within continuing care retirement communities (CCRCs), many residents face a similar life transition when increasing frailty forces a move from independent to assisted living residences. The resistance shown by many community dwelling elders moving into a nursing home is similar to the resistance seen when the move is to assisted living (AL) from independent living (IL) within a CCRC, and it is the unavoidable life transition facing many in their later years (Biedenharn & Normoyle, 1991). When residents in IL are on the verge of requiring the next level of care, medical staff, administration, and family must together help the resident see the need for a move to an assisted living facility. Most residents do not heed this advice readily; compliance

typically requires much effort from the CCRC staff. Residents who need to move to AL want to remain in their IL apartments, yet legally they are not permitted to stay in IL if they are assessed either physically or mentally at an AL level (see Appendices A & B for independent living and assisted living profiles). Residents' nearly universal resistance to this move leads us to ask: What are their fears of AL? What factors influence their perceptions of the transition to AL? After all, residents entering a CCRC facility know that as their physical or mental functioning declines, they can anticipate a move to AL or nursing care; in fact, they sign a contract to this effect. As noted earlier, the purpose of AL is to support independence and delay greater losses of independence. Why then are IL residents reluctant about moving to AL when the purpose of AL is to support autonomy and delay premature losses of independence? There is little research on IL residents' perceptions of assisted living that could shed light on the resistance to accept the move in a positive manner. Thus, the purpose of this research was to identify factors associated with successful adaptation in residential transitions in CCRC communities, and to share our findings with CCRC staff and administration whose work increasingly

involves moving residents from one level of care to the next.

## Continuing Care Retirement Communities

Continuing care retirement communities provide incremental levels of housing, health, and human services in exchange for an entry fee plus monthly payments (Netting & Wilson, 1991). Entrance fees cover the cost of capital improvements of buildings and grounds within the retirement community, and the cost of the unit that a resident selects upon move-in. These fees vary substantially, from $20,000 to $200,000, depending on the size of the facility and the quality and number of services (Blair, 2000). As noted, monthly fees are also part of the CCRC payment structure. They range from $500 to $2000 (Blair) and increase as a resident moves from one level of care to a more acute level, such as AL or skilled nursing. This pay structure has been coined "pay as you go," meaning that the higher the level of care a resident requires from the retirement community, the higher the monthly fee.

A resident can live at a continuing care retirement community for his/her entire aging process, beginning with independent living then moving on to assisted living and

finally skilled nursing. The continuum of care in a CCRC allows a resident to live independently for as long as is practical in his/her apartment with the amenities of a dining room, housekeeping, social activities, home maintenance and other support services. Individual CCRCs develop policies and procedures to assess residents' health and functional status to determine when an accommodation change is appropriate, and to decide who should be included in the decision-making process (Netting & Wilson, 1991).

In a 1991 *Consumer Reports* study (as cited in Netting & Wilson, 1991), there were approximately 800 CCRCs in the United States serving 230,000 elderly residents and in 1997, there were approximately 1200 CCRCs serving 350,000 residents (United States Department of Health and Human Services, 1997). One study indicated that about 18% of elderly people 75 and older may be CCRC residents by 2016 to 2020 (Rivlin & Wiener, cited in Netting & Wilson, 1991). *Consumer Reports* suggested that CCRCs are "within the financial reach of about 50% of the elderly" (Netting & Wilson, 1991) although many eligible people currently decide on other residential options. CCRCs exist to support a range of abilities in late-life, from the very independent elder to the elder who requires varying levels

of support in the physical, cognitive, and psychological realms as he/she ages.

## Assisted Living

Assisted living (AL) residences emerged to fill the gap in continuing care between entry-level autonomy and end-of-life medical support. AL facilities are marketed as an intermediate level of structured care for seniors who require more care than they receive living independently, but need less care than is provided in a skilled nursing facility and still allow the resident to live in a private apartment, studio, or room. AL is generally a nonmedical level of a CCRC, providing environmental support through adapted housing, specialized food service, and assistance with activities of daily living, such as help with medication dispensing, dressing, and bathing. Because AL staff provide personal services and watchful oversight to frail elders with failing physical and mental abilities (Hawes, Wildfire, & Lux, 1993), the residents-to-staff ratio in an AL unit is 3 to 1 on average (Blair, 2000).

As a social model of care, assisted living facilities are structures that provide housing and services to support resident independence (Sikorska-Simmons, 2001). AL plays

an interesting role within the CCRC structure, since it extends the period that residents can live outside nursing home facilities. There are estimated to be 35,000 licensed AL facilities with one million beds in the United States (Hawes, 1997). AL facilities in the U.S. are the fastest growing type of senior housing and have shown a 15 to 20 percent annual growth rate over the past few years. The American Association of Homes and Services for the Aging estimated that in 1999, AL accounted for 75 percent of new senior housing (Blair, 2000).

The average stay in assisted living was estimated in 1997 at 26 months, and the most common reason residents were discharged (44%) was for a higher level of care in a skilled nursing facility (Blair, 2000). In 1996, The Assisted Living Federation of America (ALFA) found that many residents in AL (48%) suffered from mental impairments, 38% used a wheelchair or walker, and 30% were incontinent. Residents' need for specific services from greatest to least were: medication dispensing, bathing, medication reminders, dressing, toileting, transferring from bed to chairs or wheelchairs, and eating (Blair, 2000).

A typical assisted living resident is an 85-year old widowed woman with a variety of functional limitations and chronic health problems (Sikorska-Simmons, 2001). The major factor in determining who the customers will be for future AL facilities is the ability to pay, restricting this level of care to relatively affluent seniors (Sikorska, 1999). AL facilities are supported by private pay; Medicaid reimbursement is not available for AL placement (Pruchno & Rose, 2000). As a result, elders who cannot afford AL are often prematurely placed in nursing home care when their mental or physical status is judged to be consistent with AL guidelines (see Appendix B: Profiles of Assisted Living). Measurement of functional status is performed by evaluating residents on instrumental activities of daily living (IADLs) such as bathing or dressing oneself. IADLs are affected by disease, physical and sensory impairments, mental status, habits, motivation, expectation, social roles, and environment (Falconer, Naughton, Hughes, Chang, Singer, & Sinacore, 1992).

## Perceptions of Assisted Living: The Lack of Research

As noted earlier, perceptions of assisted living held by independent living residents in a continuing care

retirement community have not been addressed by research. In fact, elderly individuals' views of their needs and their perceptions of what constitutes an acceptable quality of life have been largely ignored in aging research (Fry, 2000). Thus, literature regarding AL facilities is scant, with much of it describing the philosophy of AL and quality of life for those elders who are presently residing within an AL structure (Sikorska, 1999; Sikorska-Simmons, 2001). To date there have been no studies focusing on adaptation to life in AL from a prospective point of view (Pruchno & Rose, 2000).

## Community Relocation

Community relocation has long been recognized as a potential late life stressor, one requiring significant personal resources for successful negotiation, although little prior research has focused on the specific processes involved (Ryff & Essex, 1992). Relocation does not simply deal with the life event of a physical move; relocation is a psychosocial event as well. As such, life transitions can be expected to have an impact on identity and self-concept (Whitbourne, 2001), and to draw on personal resources such as life purpose and self-acceptance (Ryff & Essex, 1992).

Such features of self-concept are especially likely to be activated when older adults face the prospect of imminent relocation to a higher level of care, since the developmental task in relocation involves the negotiation of psychological as well as physical adaptation (Kling, Ryff, & Essex, 1997).

The transition that an elderly resident makes in a continuing care retirement community is not that different from an elder in a private home making a move to a nursing institution. Most prior research has focused on the transition from community to institution, and much of it exposes the negative perceptions that the elderly have regarding the change (Biedenharn & Normoyle, 1991). Typically, studies have shown that the negative perception elderly people have of moving from their own homes to a nursing home is one of the most pervasive sources of anxiety marking later life (Farrar, Ryder, & Blenkner, 1964). Because a move to a nursing home is a shift from informal to formal sources of support and forces residents to give up some personal control, it is regarded as one of the most challenging types of transitions in late life (Cantor, 1979; Lander, Brazill, & Ladrigan, 1997). Thus for both community-dwelling elders and CCRC residents, the

relocation transition involves psychological as well as physical adaptation.

Studies have consistently shown that elderly people resist moving into a nursing home or skilled nursing facility from their independent homes. One possible explanation may be found in Biedenharn & Normoyle's (1991) "quality of life hypothesis," which states that we as a society adhere to the notion that increasing one's competence represents continued development, and this continued development measures a person's worth. Clearly, moving to a higher level of care represents development that is declining and according to Biedenharn and Normoyle's hypothesis, the person's self-worth will deteriorate as well. Therefore, the possibility that one might revert to a more dependent status in a long-term care facility is a prospect which threatens self-concept (Biedenharn & Normoyle, 1991). Independent elderly going from their homes in the community respond negatively to a move to a nursing home facility due to the fact that perceptions of self as independent and autonomous are threatened when a move to a nursing home is imminent; moreover, such perceptions are fed by images of impoverished and undesirable nursing home conditions.

Perceptions of "nursing home conditions" include the image of frail residents whose days are spent parked in front of droning televisions, unable to participate in decisions about their own care and lacking in activities to keep them interested in daily life (Langer & Rodin, 1976; Rodin & Langer, 1980; Schultz & Hanusa, 1980; Wack & Rodin, 1978). We assume similar perceptions also influence considerations of IL residents anticipating a move to AL within a CCRC, even though assisted living is a more incremental move.

## Research on Community Relocation

Past studies of community relocation have focused on two aspects of the transition: reasons for moving and outcomes of the move. Studies looking at reasons for moving have tended to use variables called *push-pull* factors to characterize the relocation process (Ryff & Essex, 1992). Push-factors for an elder might be widowhood, economic problems, or deteriorating health. Pull-factors would include availability of services, neighborhood, residential design, and kinship. Ambivalence results when the elder is "pushed" to a higher level of care for (typically negative) health, economic, and loneliness reasons, and at the same time feels "pulled" to

that level of care by (typically positive) social and community incentives. A push-pull analysis of factors involved in relocation suggests that aging involves a gradual process of conceding independence and accepting greater reliance on formal support - a formal support that is at best ambivalently welcomed (Ryff & Essex, 1992). In the CCRC sample studied here, push-factors involve changes in cognitive or physical status, and pull-factors involve the social and environmental supports provided in assisted living.

Studies looking at outcomes of late life relocation show that when there is a poor fit between health related reasons for moving (push-factors) and health related supports in the new environment (pull-factors), relocating residents were generally negative about their move, (e.g., Ryff & Essex, 1992). This negativity is expressed as anxiety, confusion, depression, or loneliness (Manion & Rantz, 1995). Stress responses to relocation of the elderly from one level of care to the next have also been called "relocation shock," "transfer trauma," or "transplantation shock" (Aldrich & Mendkoff, 1963; Coffman, 1981).

In sum, even though for CCRCs there is a lack of empirical evidence on the experience of moving from one level of care to the next, especially concerning elderly individuals' fears, anxieties, and expectations (Fry, 2000), we do know that in general, elders demonstrate resistance when faced with relocation. Researchers have defined this resistance as "relocation stress syndrome" (Manion & Rantz 1995, cited in Lander et al., 1997). Research on relocation stress syndrome provides indirect evidence that elderly people's resistance to leaving their independent homes or apartments has many causes, including loss of independence and autonomy (Barrow, 1992), which contributes to a diminished sense of identity and well-being. All of the factors noted above: push-pull factors, the quality of life hypothesis, relocation stress syndrome, and generally negative perceptions of nursing home conditions help explain perceived threats that elders experience as they consider making a move to a more dependent lifestyle.

However, in the case of a move from independent living to assisted living within a continuing care retirement community, the impact of these factors is likely to be softened. First, the fit between push-pull factors is

predetermined: CCRCs have well-established criteria for levels of care, and each care level is designed to meet the needs associated with age-related changes in physical and cognitive functioning. Thus, although most past studies have looked at relocation in terms of the match between characteristics of facilities and health needs, because this match is assured in CCRCs, the push-pull hypothesis is not an adequate explanatory model for the CCRC environment. Second, one of the aims of continued care retirement communities is the preservation and maintenance of functioning and autonomy, which should make the issues of usefulness and self-worth discussed by (Biedenharn & Normoyle, 1991) less salient to these residents. Finally, the negative images associated with "typical" nursing home conditions are not as relevant to CCRCs because their philosophy and financial resources make high level late-life care the norm for their residents.

However, even with these factors wielding less influence with CCRCs' populations and even with the CCRCs' exclusive focus on accommodating residents' changing needs, nursing and administrative staff continue to report stress and resistance in the face of an imminent move (S. Anderson, personal communication, October 20, 2002).

Therefore, the task is to identify factors specific to CCRC residents' approach to the transition from IL to AL. Accordingly, we propose that individual characteristics, particularly characteristics related to self-acceptance and purpose in life, play an important role in individuals' approaches to the IL to AL transition (Ryff & Essex, 1992).

Finally, the shift in control from an independent living apartment to the level of assisted living is most often necessitated by residents' decreasing functional abilities. Competency in activities of daily living will largely determine whether or not an elder will need to make the change to AL. When elders are pushed by illness into the arms of formal support, their attitudes toward this transition from informal to formal care is often an important predictor of late-life outcomes (Chipperfield & Havens, 1991).

## Instrumental Activities of Daily Living and Their Measurement

Instrumental Activities of Daily Living (IADL) refer to the functional abilities of the elderly, and are based on norms for physical and mental functioning in late adulthood. Most IADL studies have focused on participants with some form of dementia. The current study focused on

the physical/functional abilities of independent living residents as assessed by the Lawton IADL scale (cited in Beers & Berkhow, 2002). The Lawton self-reported IADL test assesses abilities such as shopping, cooking, and managing finances. This self-report method was used rather than an informant based method, which involves having a health worker interview the resident. By self-reporting their health, IL residents assess what they believe is their physical health status and what they are capable of doing. The nature of their responses provides a picture of how residents rate their own health and creates a practical variable for perceptions of AL. Utilizing the self-reported evaluation in this study allows elderly people to feel less threatened by sensitive questions, as they do not have to discuss them with the interviewer; instead, they can take their time to study item responses. Therefore the personality of the interviewer and the way questions are read should not influence ratings (Linn & Linn, 1984).

## Coping and the Measurement of Coping

Literature (e.g., Parker & Endler, 1992) has shown that coping strategies play an important role in the way individuals react to stressful situations such as a move or

other life transition. Coping strategies also play a major role in one's physical and psychological well-being. From adolescence to adulthood and from adulthood to old age, coping allows us to deal with external and internal demands (Diehl, Coyle, & Labouvie-Vief, 1996). In adolescence there is a preference for external coping strategies, such as turning against an object by verbally and physically denouncing something. As one matures, coping strategies become more inward, evidencing less of the aggression seen in adolescence. Adulthood is characterized by reductions in "overt" coping mechanisms, such as aggression, projection, rejection, or displacement (Diehl et al., 1996). Still, coping mechanisms are generally consistent across the lifespan, and match the person and the task (Diehl et al.). The difference between young and older adults is that situations become less interpretable in old age and the capacity for resilience is compromised. As a result, older adults may cognitively distance themselves from a situation, ignoring the problem and inviting denial.

Research on coping in adulthood has identified three styles of coping with life challenges: task-oriented, emotion-oriented, and avoidance-oriented. Task-oriented coping allows one to solve a particular problem, to

cognitively reconceptualize it or minimize the effect; emotion-oriented strategies utilize our emotional responses and give us the ability to fantasize reactions; and avoidance-oriented strategies involve engaging in distracting activities (distraction component) or seeking out other people (social diversion component) (Parker & Endler, 1992). Their analysis showed that emotion-oriented coping and the distraction component of avoidance-oriented coping are positively correlated with psychiatric disorders, whereas task-oriented coping and the social diversion component of avoidance-oriented coping are negatively related to depression and not related to other psychiatric disorders (Parker & Endler, 1992).

Successful relocation means being able to cope with the prospect of a new home, new friends, new area of locale, and new activities. Such transitions are defined by uncertainty, and the stress of uncertainty reveals basic and preferred modes of coping. A move to assisted living might find an elder making the effort to reframe the situation as an opportunity for extended autonomy (task-oriented), fantasizing the reality of the move as a kind of rehearsal (emotion-oriented), or distancing him/herself or engaging in some diverting activity to distract themselves

from the implications of moving (avoidance-oriented). While the move to AL can be prolonged and difficult for both staff and elder, the stress of relocation depends in part on adaptive coping.

Although coping measures have received a lot of attention in psychology, ironically, few measures are considered reliable and valid (Endler & Parker, 1994). There is disagreement in the literature on the applicability and psychometric properties of existing scales. Some researchers have criticized coping scales for using inappropriate factor-analytic techniques, failing to cross-validate coping measures with different populations, and failing to distinguish stylistic (trait-like) coping and situation-specific (state-like) coping (Coyne & Gottlieb, 1996). Partly in answer to these criticisms, Endler and Parker developed a scale that is multidimensional and situation-specific (1994). The Coping Inventory for Stressful Situations Scale (CISS) shows a stable factor structure, and has coefficient alphas ranging from .73 to .92 across a variety of normative samples (Endler & Parker, 1994). This scale has four possible scenarios, and this study used the *Change in social*

*situation* scenario, since a move to AL is a change in social situation.

## Psychological Well-Being and the Measurement of Psychological Well-Being

Well-being is considered a subjective state that is based on a person's own standards and criteria (Clarke, Marshall, Ryff, & Rosenthal, 2000). The term psychological well-being is associated with a broad, or global, sense of subjective well-being that refers to one's state of mind as opposed to one's actions, and is synonymous with the philosophical term happiness (Kozma, Stones, & McNeil, 1991). The well-being construct provides a basis in theory for examining the effects of specific PWB dimensions, self-perceived autonomy and positive sense of self on major transitions in life. Here the well-being construct is applied to late-life transitions, specifically the move from IL to a higher level of care.

The most widely used measure for well-being was developed by Carol Ryff (1995). The scale was developed for applications across adulthood; it is often used to assess well-being among elders in transition (Ryff et al., 1992). Ryff identifies six dimensions of well-being: autonomy, including the qualities of self-determination;

independence, and the regulation of behavior from within; environmental mastery, which is the individual's ability to engage in, and manage, activities in one's surrounding world; personal growth, which represents one's continual development and striving to realize one's potential to grow and expand as a person; positive relations with others, including the ability to achieve close unions with others; purpose in life, including the beliefs that give one the feeling that there is purpose in and meaning in life; and self-acceptance, positive attitudes towards oneself.

Each of these domains of the self plays a particular role in elders' perceptions of transitions. For instance, *autonomy* relates to self-perceived independence of an elder as they begin to rely on more formal support. A sense of *environmental mastery* in the present influences their expectations for mastery in a new environment. Current levels of *personal growth* may predict growth when the elder cannot readily do things for him/herself and must find new ways to continue on in the learning continuum of life. *Positive relations with others* in the present may help an elder remain focused on relationships in the smaller social circle of AL. Elders who have faced the challenges of aging pro-actively with a sense of *purpose in life* may be

better equipped to find meaning, even in failing health. *Self-acceptance,* through a realistic approach to the struggles of growing old, may help the elder accommodate changes to self-concept brought about by the need for assistance in living.

## Perceptions of Assisted Living

Perceptions of assisted living, the dependent variable, is defined as resident satisfaction and measured by the Resident Satisfaction Index (RSI) scale (Sikorska-Simmons, 2001). In its original form, the scale measures perceptions of AL by residents themselves reporting *in situ*. Here, the measure has been adapted to assess *prospective* AL satisfaction. This approach is important because residents' individual views or perceptions of a specific AL facility will be evaluated, rather than their general attitude toward the transition from IL to AL. In other words, the present study did not ask residents to think of a hypothetical move situation as previous studies have done; rather, the study tests perceptions of residents who are one step away from the real possibility of a move to AL.

The Measurement of Perceptions of Assisted Living

Perceptions of assisted living have largely been ignored in the literature. Studies have looked at general age-related beliefs among the elderly or at "quality of life" to determine how elders perceive nursing homes, assisted living facilities, or retirement facilities. The only study that has directly addressed perceptions of AL is a study by Marsden (1999), who discussed elders' perceptions of homeyness in AL. Marsden studied the physical environment and architecture in AL facilities, looking at perceptions of aesthetics. Given the absence of literature on how IL residents perceive AL, research on elders in their homes anticipating a move to a nursing facility provides the closest parallel (Biedenharn & Normoyle, 1991). Perceptions of nursing homes in the Biedenharn and Normoyle study pointed out "beliefs or reactions" to the idea of someday moving into a nursing home. These beliefs or perceptions (again mostly negative) revealed a healthy person's fear of one day having to enter a nursing home, as well as their estimates of the likelihood of so doing. Within a CCRC, it is expected that most elders will move to the level of AL. In past

research, nursing home perceptions were taken from community-dwelling elders living outside retirement communities, who often had not planned for or even expected the move. In contrast, the present study, conducted in a system of CCRCs which market a predictable levels-of-care scenario, looks at residents' perceptions of an anticipated and familiar life transition.

## Summary of Research Problem and Rationale for Hypotheses

An independent living resident in a continuing care retirement community going from his/her apartment to an assisted living apartment does not receive 100% formal support as they would receive in a nursing home. Previous studies have focused on the typically abrupt move to a nursing home or skilled nursing facility. Because little research has been done on CCRC residents, professionals and researchers have relied on findings from nursing home studies. However, it is inappropriate to equate a move to a nursing facility with a move to AL; there is not a one-to-one correspondence between the two levels of care.

The question is: how do we view this intermediate step? On the one hand it is a road that is traveled to less and less autonomy, where one's dignity must come from

others' perceptions. On the other hand, it is a road that offers the kind of support that preserves autonomy, and preserving an elder's autonomy helps keep them the object of other peoples' invested attention.

The purpose of this study is to examine residents' perceptions of the transition to AL as a function of psychological well-being, physical competence, and coping styles, in order to determine the factors that influence IL residents' perceptions of assisted living before they are faced with making the move to AL. The criterion variable was residents' perceptions of AL, and the predictors were residents' view of his/her psychological well-being, his/her self-reported competence in instrumental activities of daily living, and his/her coping strategies.

## Significance and Implications

This study addresses the lack of research regarding perceptions of the assisted living facility within a continuing care retirement community. It is meant to shed light upon the booming industry of assisted living facilities and on the trepidation that residents show as they look toward a move to supported living. As great numbers of baby-boomers approach retirement, they are the

likely consumers of the retirement industry, and research which can help facilitate late-life transitions will be in much demand. In 2020 it is projected that 18% of the population will be over the age of 65 (Mitchell & Kemp, 2000) and by 2030 elders will comprise more than 20% of the nation's total population (Ferrini & Ferrini, 2000). The baby-boomer generation is the generation that has been most involved in negotiating care for their elderly parents. For this reason, they are more knowledgeable than previous generations have been, they are more active researchers on aging, and they know the options that are available to elders, including CCRCs. Moreover the baby-boomers are pro-active in evaluating late life alternatives (because they have considered late life options for their parents) which makes them far more aware and focused in their retirement plans than their parents ever were (Corr, Nabe, & Corr, 2000).

Therefore, the baby-boomer generation is shaping the way CCRCs govern and market themselves; such organizations are now looking at the whole person rather than their collection of physical and cognitive impairments. Aging research was once focused on end-of-life stages (e.g., Erikson, 1982). A concept like AL reflects the current

research, in that it focuses on preserving autonomy in a context of adaptive aging. The philosophy and organization of contemporary retirement communities focus on the autonomy of the person, psychological well-being, coping, and physical and cognitive abilities, which together reflect the current biopsychosocial perspective on aging (Baltes & Graf, 1996; Birren & Renner, 1977; Whitbourne, 1996).

## Hypotheses and Predictions

The following exploratory hypotheses and predictions guided the present study. We selected three variables to predict retirement community dwellers' attitudes toward a move from independent to assisted living. The first set of variables is related to psychological well-being, which has six dimensions: autonomy, environmental mastery, personal growth, positive relations with others, self acceptance, and purpose in life. Past literature on late-life transitions has used psychological well-being as an outcome measure; in this study we treat psychological well-being as an antecedent to transition outcomes. In using these six well-established features of psychological well-being as predictor variables, we have relied on contemporary

literature in positive psychology, which emphasizes the positive effect of mastery, quality ties to others, self-esteem, and purpose in life (Ryff & Singer, 2000) on successful late-life transitions. We hypothesized that high scores on each of the six dimensions of psychological well-being would be associated with positive perceptions of assisted living (AL). The second set of predictor variables was instrumental activities of daily living (IADL). Research has shown that self-reported assessment of functional status accurately predicts impending change in level of care in a CCRC; however, residents' perceptions of the next level of care have not been examined in relation to functional status (Falconer et al., 1992). We hypothesized that physically compromised residents would have more negative attitudes towards AL than their healthier counterparts. This is predicted because of the observed reticence of independent living residents who are closer to assisted living. That is, those who are closer to needing the next level of care have a more negative view of it because they are dealing with the situation more immediately and practically, whereas the possibility of needing more care is more theoretical for those who are further away from an impending move. The third set of

predictor variables is coping style, measured as avoidant-oriented, task-oriented, and emotion-oriented coping. Past literature suggests that in general, older adults use more mature defense mechanisms in coping with stressful events when compared with younger adults (Diehl et al., 1996). However, the literature also suggests that specific stress situations make a difference: When faced with an irresolvable stressor no single coping style is likely to be effective (Whitbourne, 2001). Because our late-life adaptive challenge scenario, in contrast with decisions characteristic of earlier life, involves an unavoidable outcome, we expected to find evidence of all three coping strategies. But we also expected a preference for emotion and task-oriented coping styles to be related to positive perceptions of assisted living, because avoidance-coping strategies would hinder a person from confronting the prospect of moving to AL.

# CHAPTER TWO

# METHOD

## Sample

The data for the present study were collected from independent living residents at six non-profit continuing care retirement communities in Florida, California (2), Connecticut, Illinois, and Oregon.

The subjects were all middle class to upper-middle class background and all over the age of 62. There were 301 participants: 105 males, 188 women, and eight declining to specify gender. Two participants had education less than high school, 51 had a high school level of education, 134 had an undergraduate college degree, and 108 had attended graduate school. In terms of income level, 53 participants reported incomes of less than $25,000 annually, 125 had incomes between $25,000 and $50,000, 68 between $50,000 and $75,000, 24 between $75,000 and $100,000, and 8 greater than $100,000. Twenty-three elders declined to answer the question. There were 288 participants who reported themselves to be Caucasian, 10 reported Native American, one as "other," and two declined to answer (Appendix C).

## Materials and Procedure

Residents were recruited for the study via closed-circuit television, weekly newsletters, and public announcements. The questionnaire consisted of 110 items covering four measures: the Lawton Instrumental Activities of Daily Living scale (8-items, Lawton IADL scale, cited in Beers & Berkhow, 2002, Appendix D); the Coping Inventory for Stressful Situations:Situation Specific Coping scale (21-items, Endler & Parker, 1999,Appendix E); the Psychological Well-Being Scale is comprised of 54 questions (54-items, Ryff, 1989, Appendix F); and the Resident Satisfaction Index (27-items, Sikorska-Simmons, 2001, Appendix G). Volunteer participants were given questionnaire packets, including debriefing and consent forms (Appendices H and I) to be completed within one week and returned to designated staff.

The Lawton Instrumental Activities of Daily Living Scale (IADL) assesses housekeeping, laundry, meal preparation, shopping, mobility outside of the home, money management, medication use, and telephoning. It includes questions such as, "Do you do your housekeeping, laundry, and meal preparation with ease?" Other questions pertain to self-autonomy in dealing with personal finances such as,

"Do you handle your own money?" Residents self-assess their autonomy and independence by rating their ability to accomplish daily living tasks on the IADL.

Using the instrumental activity of daily living scale, participants indicate if they: 1) need no help; 2) need some help; or are 3) unable to do a task in each of eight areas. Two points are awarded if the participant needs no help with a particular task, one point if the participant needs some help, and zero points if someone else must do a task for them. The score range is from zero to sixteen. This scale has been used since 1969 (Lawton & Brody) and is generally considered the standard for self-assessment of daily function in the elderly.

The Coping Inventory for Stressful Situations: Situation Specific Coping (CISS:SSC) Scale presents a hypothetical stressful situation, and participants answer 21 questions which tap their preferences for three types of coping: task-oriented, emotion-oriented, and avoidance-oriented (Endler & Parker, 1994). This scale is scored 1 (not at all) to 5 (very much), with a score range of 21 to 105. Psychometrics for the larger Coping Inventory for Stressful Situations scale (of which the CISS:SSC is a subset), show a Cronbach's alpha reliability rating of .86

for task oriented items, .89 for emotion oriented items, and .87 for avoidance oriented items, indicating good internal consistencies (Cosway, Endler, Sadler, & Deary, 2000). The study scenario adapted from the Change in Social Situation Scenario, to reflect a move to Assisted Living asked the resident to envision themselves making a move from IL to AL. It included questions such as, "How often do you blame yourself for getting into a situation?" Assessing an IL resident's coping skills is expected to give insight into how coping skills contribute to a negative or positive perception of a move to AL.

The Psychological Well-Being Scale (PWBS) has six 9-item scales: 1) autonomy; 2) environmental mastery; 3) personal growth; 4) positive relations with others; 5) purpose in life; and 6) self-acceptance. Responses range from 1 (strongly disagree) to 6 (strongly agree), with a score range of 54 to 324. The PWBS has intercorrelations ranging from 0.13 to 0.46 and internal consistency ranging from 0.33 to 0.56 (Ryff & Keyes, 1995). Well-being is defined in terms of scores on each of these six subscales. For instance, one item assessing the autonomy dimension reads, "I have confidence in my own opinions, even if they are contrary to the general consensus"; another item,

tapping personal growth, reads, "For me, life has been a continual process of learning, changing, and growth."

The Resident Satisfaction Index (RSI) scale has 5 dimensions: 1) health care; 2) housekeeping services; 3) physical environment; 4) relationships with staff; and 5) social life/activities. Items are scored from 1 (never) to 5 (always), with a score range of 27 to 135. Internal consistency for the RSI subscales range from 0.76 to 0.86 and item-total correlations range from 0.37 to 0.77, with a Cronbach's alpha reliability of 0.92 (Sikorska-Simmons, 2001). Items were worded in the future tense, because the current study is prospective. For example, the RSI item "Is the staff making every effort to keep you as healthy as possible?" has been changed for our study to read "*Do you think the staff makes every effort to keep residents as healthy as possible?*"

## Design and Analysis

In this study a correlation-regression approach was adopted to investigate the relationships between the criterion variable, perceptions of assisted living (PAL) and each of the following three sets of predictor variables: psychological well-being (PWB-autonomy, PWB-

relations with others, PWB-environmental mastery, PWB-purpose in life, PWB-self-acceptance, PWB-personal growth); instrumental activities of daily living (IADL), and coping strategies (coping-task, coping-emotion, coping-avoidance). As noted, perceptions of assisted living were measured by the Resident Satisfaction Index (RSI), psychological well-being was measured by the Psychological Well-Being Scale (PWBS), instrumental activities of daily living (IADLs) were measured by the Lawton Instrumental Activities of Daily Living Scale, and coping strategies were measured by the Coping Inventory for Stressful Situations: Situation Specific Version (CISS:SSC). All variables are quantitative and continuous.

Pearson product-moment correlation coefficients between PAL and each dimension of PWB, IADL, and each dimension of coping were calculated, and their significance tested. A significance level of $p=.05$ was adopted to conclude statistical significance for the results. Further, stepwise multiple regression analyses were conducted to determine 1) which subset of the PWB dimensions best predicted PAL, and 2) which subset of the coping dimensions best predicted PAL. Additional analyses

were conducted to examine the effect of demographic factors on the variables above.

# CHAPTER THREE

## RESULTS

A large number of surveys was returned (434 out of 600 distributed, a 72% response rate overall). Data were analyzed using SPSS Version 11.5 for Windows. Among the six campuses to which surveys were distributed, return rates ranged from a high of 97% and a low of 36%. The returned surveys were examined for missing and incomplete data. Using a minimum completion rate of 70% responses per measured variable surveys below this criterion were excluded from the analysis. This reduced the number of usable surveys to 301, and results reported here are based on these surveys.

Table 1 presents Pearson product-moment correlation coefficients between the criterion variable and each predictor variable. As this Table shows, all three sets of variables predicted residents' perceptions of assisted living (PAL), however, among the coping styles, only emotion-oriented coping was significant.

Table 1. Correlations Between the Criterion Variable and Each Predictor Variable

| Predictor Variable | The criterion variable: Perceptions of assisted living |
|---|---|
| Psychological well-being | |
| PWB-Autonomy | .196** |
| PWB-Environmental mastery | .274** |
| PWB-Personal growth | .289** |
| PWB-Positive relations with others | .388** |
| PWB-Purpose in life | .316** |
| PWB-Self acceptance | .305** |
| Instrumental activities of daily living (IADL) | -.123* |
| Coping Style | |
| Coping-Avoidant | -.040 |
| Coping-Task oriented | .103 |
| Coping-Emotion oriented | -.163** |

*$p \leq .05$; ** $p \leq .01$.

## Psychological Well-Being and Perceptions of Assisted Living

As noted, each of the six dimensions of psychological well-being was significantly correlated with perceptions of assisted living, such that, as predicted, the higher the scores on PAL (i.e., more positive perceptions of assisted living). Results for the stepwise regression analysis (Table 2) indicated that among the six dimensions of PWB, the combination of PWB-positive relations and PWB-self-acceptance provided the best prediction of PAL.

Table 2. Summary of Stepwise Regression Analysis for Psychological Well-Being Variables Predicting Perceptions of Assisted Living

| Predictor Variable | *B* | *SE B* | *β* |
|---|---|---|---|
| Step 1 | | | |
| PWB-Positive relations with others | .175 | .024 | .388 |
| Step 2 | | | |
| PWB-Positive relations with others | .142 | .027 | .315 |
| PWB-Self acceptance | .747 | .029 | .155 |

Note: $R^2 = .151$ for Step 1 ($p < .01$); $\Delta R^2 = .018$ for Step 2 ($p < .01$).

## Instrumental Activities of Daily Living and Perceptions of Assisted Living

As can be seen from Table 1, instrumental activities of daily living (IADL) was mildly but significantly correlated with perceptions of assisted living ($r = -.123$, $p < .05$); that is, the lower the IADL scores (i.e., greater need of help with everyday self-care), the higher the scores on PAL (i.e., more positive perceptions of assisted living). Table 3 summarizes the corresponding regression analysis. As can be seen from this table, IADL significantly predicted PAL, but not in the predicted direction, as we had expected low IADL scores to be associated with negative perceptions of AL.

Table 3. Summary of Regression Analysis for Instrumental Activities of Daily Living as the Predictor of Perceptions of Assisted Living

| Predictor Variable | *B* | *SE B* | *β* |
|---|---|---|---|
| Instrumental Activities of Daily Living | -.243 | .114 | -.123 |

Note: $R^2 = .015$ ($p < .05$).

## Coping Style and Perceptions of Assisted Living

Table 1 also shows that of the three coping styles examined in the study, only emotion-oriented coping was significantly correlated with perceptions of assisted living ($r = -.163$, $p < .01$). The lower the emotion-oriented coping scores (i.e., less reliance on emotion-focused strategies for dealing with everyday problems), the higher the scores on PAL (i.e., more positive perceptions of assisted living). Results for the stepwise regression (Table 4) indicated that among the three coping styles, coping-emotion oriented and coping-task oriented together provided the best prediction of PAL. The last result was consistent with our predictions, as avoidance-oriented coping did not act as a predictor of residents' perceptions of AL.

Table 4. Summary of Stepwise Regression Analysis for Coping Styles Predicting Perceptions of Assisted Living

| Predictor Variable | *B* | *SE B* | *β* |
|---|---|---|---|
| Step 1 | | | |
| Coping-Emotion oriented | -.0812 | .028 | -.163 |
| Step 2 | | | |
| Coping-Emotion oriented | -.0946 | .029 | -190 |
| Coping-Task oriented | .0564 | .023 | .140 |

Note: $R^2$ = .027 for Step 1 ($p < .01$); $\Delta R^2$ = .019 for Step 2 ($p < .05$).

# CHAPTER FOUR

# DISCUSSION

The aim of the present research was to understand independent living (IL) residents' attitudes towards a move to assisted living (AL) within a continuing care retirement community (CCRC). With scant research on this subject available in the gerontological literature, it was necessary to draw on studies of nursing home transitions for guidance. This literature has shown mostly reticence on the part of home dwelling elders moving to AL or nursing facilities and we assume a similar reticence on the part of the CCRC residents, but we could locate no studies addressing this group of elders. Although there is much individual variability in aging trajectories, residents within a CCRC know that moving from one level of care to the next is expected when health in status changes; in fact, as noted earlier, a contract at the time of move-in is signed to this effect.

To examine the perspective of residents within a CCRC contemplating a move from IL to AL, we used three measures as predictor variables that have been used in prior late-life relocation studies; personal well-being, instrumental

activities of daily living, and coping. Past literature on late-life transitions has used psychological well-being (PWB) as an outcome measure; in this study we treated psychological well-being as an antecedent to transition outcomes. And out of the six dimensions of PWB, all six were significantly correlated with positive perceptions of AL. Moreover, results of the regression analysis showed that PWB-positive relations with others and PWB-self-acceptance combined were the best predictors of perceptions of AL. These findings suggest that a developmental history of accepting and caring for both oneself and others allows an elderly person to adapt to even major life transitions successfully. Thus, elders who maintain ties to others, and who accept themselves as aging beings with the problems that may arise physically and mentally as they continue on in the aging spectrum, are likely to be more amenable to the prospect of assisted living.

The second predictor variable was Instrumental Activities of Daily Living (IADL). We hypothesized that lower scores on this scale would be related to more negative perceptions of AL. This hypothesis was not supported, as low IADL scores were related to positive AL attitudes. At the outset we noted that past research had

shown that decreases in functional status had a negative effect on the ability to cope with change. Thus a resident in IL who is frailer than her peers may acknowledge that a move to AL is inevitable, but may have a difficult time accepting the reality, particularly as it moves closer. Based on this we had expected that functional impairment would be reflected in negativity regarding AL. Instead it appears that elders needing help may actually be re-assured by AL facilities even though the move is not welcomed.

An unavoidable life change, such as a move to AL from IL, mobilizes coping mechanisms (the third predictor variable), and in this research emotion-oriented coping was found to be a predictor of negative perceptions of AL and when combined with task-oriented coping, provided the best coping-related prediction of perceptions of AL. (Avoidance-oriented coping was not significantly related to perceptions of AL). Residents who showed a preference for emotion-oriented coping strategies may not be able to handle the psychological demands of an impending move, and may dwell on negative aspects of the transition such as giving up some control in exchange for needed assistance. Task-oriented residents may be better at imagining the move to AL as something they are doing to enhance their quality

of life, and so are willing to confront it directly without wringing their hands over it.

Results from this study offer a number of insights to the study of perceptions of AL. First, they suggest that elders' realistic assessments of both psychological and physical abilities influence perceptions of AL. Second, they suggest that the resistance to increased levels of care observed by professionals and family among CCRC dwellers may be more related to acceptance of self and others (and thus of aging) than to negativity toward the AL concept itself. Finally, the results here suggest (in line with general coping research findings) that with age, coping styles may become more situation-specific but pro-active involvement continues to be important to adaptation.

Continued research is necessary if we are to understand the specific life circumstances of CCRC elders. Given the findings of this study, it is clear there are many other possible factors influencing perceptions of assisted living, including the social support residents receive from family and friends, and the quality of the education provided to residents throughout the CCRC continuum.

Limitations of this study include the organization type, the composition of our sample, and the time frame we employed. All CCRC campuses studied were from a non-profit church-owned organization. Research should be done on for-profit CCRC's not affiliated with an ecumenical group. This study was largely homogeneous ethnically; research in a more diverse population is needed. Finally, more long-term study is needed to do follow-up on participants and their long-term adjustment if they do indeed make a move to AL. Understanding how elders negotiate late-life is enhanced through longitudinal inquiry. Research over time would reveal elders' sense of the trajectory of their own aging, and perhaps show us how reactions to aging influence the ability to accommodate to changed circumstances.

# APPENDIX A

# PROFILES FOR INDEPENDENT LIVING

Mobility/Ambulation

Independently walks and transfers without a device. May only use device (can or walker) in independent living apartment or for long distances (i.e. to dining room) throughout campus. May not be wheelchair dependent. Must be able to ambulate independently and without assistive devices in main dinging room. Must leave assistive devices (wheelchair, walkers) outside (and canes in designated containers) unless accompanied by someone who can assist the resident, (i.e. - residents from Assisted Living or Skilled Nursing who like to eat with families). Functional range of motion. Must be able to exit all buildings (apartment, dining room, activity rooms) without assistive devices and walk 100' beyond buildings in case of an emergency (unless accompanied by someone who can assist). NOTE: ADA regulations are accommodated for.

ADL's

Independent in all ADLs. Ability to self manage laundry and light housekeeping duties. Able to make own MD appointments. Able to prepare meals safely and independently. Resident must exhibit ability to order and self-administer medications. May receive assistance with ADLs through home care while in a transitional stage to

higher level of care or when recuperating from an injury/illness. Residents must utilize nursing services requested at the clinic (unless it is an emergency, residents are ill or have had a recent hospital discharge). Continent or exhibit consistent ability to self manage incontinence. Ability to self manage oxygen use if applicable. May perform ostomy care with waivers.

Cognition

Cognition scale: = 0. Mood/behavior doesn't affect social environment. Oriented to person, place and time. Memory intact. Able to reason, organize, plan and respond. Displays no symptoms of debilitating anxiety, phobias, or dementia.

Safety

Safety of self and others, ability to self manage falls. Proven ability to evacuate apartment and buildings independently and walk 100' beyond buildings without assistive devices in the event of an emergency. Exhibits ability to recognize emergencies and take appropriate action.

Communication

Ability to make self understood and understands others.

Psychosocial

Exhibits socially appropriate behavior. Attends activities periodically at a minimum. Ability to manage finances either independently or with assistance. Does not exhibit signs of alcohol or drug misuse.

# APPENDIX B

# PROFILES FOR ASSISTED LIVING

Mobility/Ambulation

Independently ambulates with or without a device a minimum of 300 feet on a daily basis. May not be wheelchair dependent. Must be able to transfer from bed and sit to stand independently. May exhibit some mild to moderate range of motion impairment and some occasional balance or unsteadiness. Must be able to exit building (with use of a mechanical device) within 5 minutes.

ADL's

Resident requires assistance with some portion of up to 5 ADLs on a daily basis. Resident must be able to dress independently but may receive assistance with clothing choices. Residents generally require daily supervision or assistance with medications. Must be able to eat independently. Residents must partake of a minimum of 1-2 meals/day in the dining room. May require trays for short-term medical reasons. May require assistance with cutting food and opening containers at mealtime. May require reminders from staff for mouth care. Generally requires staff assistance to carry out laundry function. May require supervision to/from medical appointments. Skin intact. Requires daily supervision by licensed and/or unlicensed staff to monitor medical condition. Medication

monitoring by licensed/non-licensed staff. Supervised medications stored in a central location. Residents' medications stored in locked box in resident rooms. Psychotropic and anti-anxiety medications and narcotics will be supervised by the licensed nurse and the Pharmacy Consultant. May not have 9+ medications prescribed without involvement / review by primary physician and pharmacist and documented as appropriate in the medical record. Must be able to self-manage alcohol intake.

Continence

Continent or self-managed. May receive up to 3 weeks of bowel and bladder training as needed.

Cognition

Cognitive level: Stage 1 - short and long term memory loss evident, some personality changes, difficulty calculating problems, may not make safe decisions independently, exhibits difficulty concentrating, exhibits declining ability to self manage ADL's. Coping skills may be limited. Socially appropriate. May exhibit sudden mood changes. Able to make independent meal choices. Wandering without purpose is not an option.

Safety

May require staff cueing for exiting building. May have falls that when interventions are in place, they are effective in reducing frequency of the falls. May require staff supervision/assistance to/from medical appointments.

Communication

Increased difficulty communicating needs.

Psychosocial

Most likely unable to independently manage finances. Participates in activities with AL setting. Difficulty integrating with IL activity programming due to hearing, vision and/or cognitive impairments. No signs of drug/alcohol misuse.

# APPENDIX C

## DEMOGRAPHIC QUESTIONNAIRE

PLEASE NOTE THAT YOUR RESPONSES ARE STRICTLY CONFIDENTIAL.

PLEASE TRY TO ANSWER AS MANY QUESTIONS AS POSSIBLE TO THE BEST OF YOUR KNOWLEDGE. THANK YOU FOR YOUR PARTICIPATION.

1. What is your gender? (circle one)

   Male Female

2. What is your highest education level? (circle one)

   High school
   Undergraduate college
   Graduate school

3. What is your yearly income? (your best estimate) Please circle the number that applies.

   1. Less than $25,000
   2. $25,001-$50,000
   3. $50,001-$75,000
   4. $75,001-$100,000
   5. Greater than $100,001

4. What kind of work did you do before retirement? _____

5. What kind of work did your spouse do before retirement? (if applicable)
   _____

6. Which of the following best describes your birth family's background? (circle one)

   African American
   Latino, Chicano, or Hispanic
   Caucasian
   Asian
   Native American
   Other (please specify) _____

# APPENDIX D

# LAWTON INSTRUMENTAL ACTIVITIES OF DAILY LIVING SCALE

**Please circle the choice that best answers the question.**

1. Can you prepare your own meals?
   Without help
   With some help
   Are you completely unable to prepare any meals?

2. Can you do your own housework or handyman work?
   Without help
   With some help
   Are you completely unable to do any housework?

3. Can you do your own laundry?
   Without help
   With some help
   Are you completely unable to do any laundry?

4. Do you or can you take prescribed drugs?
   Without help (i.e., correct doses at correct time)
   With some help (someone prepares the drug and or reminds you to take it)
   Are you completely unable to take prescribed drugs without help?

5. Can you get to places beyond walking distance? (for example, beyond the dining room)
   Without help
   With some help
   Are you completely unable to travel unless special arrangements are made?

6. Can you go shopping for groceries?
   Without help
   With some help
   Are you completely unable to do any shopping?

7. Can you manage your own money?
   Without help
   With some help
   Are you completely unable to manage money?

8. Can you use the telephone?
   Without help
   With some help
   Are you completely unable to use the telephone?

# APPENDIX E

# COPING INVENTORY FOR STRESSFUL SITUATIONS:

# SITUATION-SPECIFIC COPING

**The following are ways people react to various situations. Please circle a number from 1 to 5 for each item. Indicate how much you might engage in these types of activities if you were faced with the following scenario.**

**Scenario:**
**One of your clinic nurses makes an appointment to talk with you about making a move from independent living to assisted living. This would cause you to...**

| | Not at All | | | | Very Much |
|---|---|---|---|---|---|
| 1. Take some time off and get away from the situation. | 1 | 2 | 3 | 4 | 5 |
| 2. Focus on the situation and see how I can solve it. | 1 | 2 | 3 | 4 | 5 |
| 3. Blame myself for having gotten into this situation. | 1 | 2 | 3 | 4 | 5 |
| 4. Treat myself to a favorite food or snack. | 1 | 2 | 3 | 4 | 5 |
| 5. Feel anxious about not being able to cope. | 1 | 2 | 3 | 4 | 5 |
| 6. Think about how I solved similar situations. | 1 | 2 | 3 | 4 | 5 |
| 7. Visit a friend. | 1 | 2 | 3 | 4 | 5 |
| 8. Determine a course of action and follow it. | 1 | 2 | 3 | 4 | 5 |
| 9. Buy myself something. | 1 | 2 | 3 | 4 | 5 |
| 10. Blame myself about being too emotional about the situation. | 1 | 2 | 3 | 4 | 5 |
| 11. Work to understand the situation. | 1 | 2 | 3 | 4 | 5 |
| 12. Become very upset. | 1 | 2 | 3 | 4 | 5 |
| 13. Take corrective action immediately. | 1 | 2 | 3 | 4 | 5 |
| 14. Blame myself for not knowing what to do. | 1 | 2 | 3 | 4 | 5 |
| 15. Spend time with a special person. | 1 | 2 | 3 | 4 | 5 |
| 16. Think about the event and learn from my mistakes. | 1 | 2 | 3 | 4 | 5 |
| 17. Wish that I could change what is happening and how I felt. | 1 | 2 | 3 | 4 | 5 |
| 18. Go out for a snack or meal. | 1 | 2 | 3 | 4 | 5 |
| 19. Analyze the situation before reacting. | 1 | 2 | 3 | 4 | 5 |
| 20. Focus on my general inadequacies. | 1 | 2 | 3 | 4 | 5 |
| 21. Phone a friend. | 1 | 2 | 3 | 4 | 5 |

# APPENDIX F

# PSYCHOLOGICAL WELL-BEING

# SCALE

**Please circle the number which corresponds to the choice that best describes your attitude.**

**1=Strongly disagree, 2=Disagree somewhat, 3=Disagree slightly, 4=Agree slightly, 5= Agree somewhat, 6=Strongly agree**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | I am not afraid to voice my opinions, even when they are in opposition to the opinions of most people. | 1 | 2 | 3 | 4 | 5 | 6 |
| 2. | My decisions are not usually influenced by what everyone else is doing. | 1 | 2 | 3 | 4 | 5 | 6 |
| 3. | I tend to worry about what other people think of me. | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. | Being happy with myself is more important to me than having others approve of me. | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. | I tend to be influenced by people with strong opinions. | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. | I have confidence in my opinions, even if they are contrary to the general consensus. | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. | It's difficult for me to voice my own opinions on controversial matters. | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. | I often change my mind about decisions if my friends or family disagree. | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. | I judge myself by what I think is important, not by the values of what others think is important. | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. | In general, I feel I am in charge of the situation in which I live. | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. | The demands of everyday life often get me down. | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. | I do not fit very well with the people and the community around me. | 1 | 2 | 3 | 4 | 5 | 6 |
| 13. | I am quite good at managing the many responsibilities of my daily life. | 1 | 2 | 3 | 4 | 5 | 6 |
| 14. | I often feel overwhelmed by my responsibilities. | 1 | 2 | 3 | 4 | 5 | 6 |
| 15. | I generally do a good job of taking care of my personal finances and affairs. | 1 | 2 | 3 | 4 | 5 | 6 |
| 16. | I am good at juggling my time so that I can fit everything in that needs to get done. | 1 | 2 | 3 | 4 | 5 | 6 |
| 17. | I have difficulty arranging my life in a way that is satisfying to me. | 1 | 2 | 3 | 4 | 5 | 6 |
| 18. | I have been able to build a home and a lifestyle for myself that is much to my liking. | 1 | 2 | 3 | 4 | 5 | 6 |
| 19. | I am not interested in activities that will expand my horizons. | 1 | 2 | 3 | 4 | 5 | 6 |
| 20. | I don't want to try new ways of doing things--my life is fine the way it is. | 1 | 2 | 3 | 4 | 5 | 6 |
| 21. | I think it is important to have new experiences that challenge how you think about yourself and the world. | 1 | 2 | 3 | 4 | 5 | 6 |
| 22. | When I think about it, I haven't really improved much as a person over the years. | 1 | 2 | 3 | 4 | 5 | 6 |
| 23. | I have the sense that I have developed a lot as a person over time. | 1 | 2 | 3 | 4 | 5 | 6 |

| | |
|---|---|
| 24. I do not enjoy being in new situations that require me to change my old familiar ways of doing things. | 1 2 3 4 5 6 |
| 25. For me, life has been a continuous process of learning, changing, and growth. | 1 2 3 4 5 6 |
| 26. I gave up trying to make big improvements or changes in my life a long time ago. | 1 2 3 4 5 6 |
| 27. There is truth to the saying you can't teach an old dog new tricks. | 1 2 3 4 5 6 |
| 28. Most people see me as loving and affectionate. | 1 2 3 4 5 6 |
| 29. Maintaining close relationships has been difficult and frustrating for me. | 1 2 3 4 5 6 |
| 30. I often feel lonely because I have few close friends with whom to share my concerns. | 1 2 3 4 5 6 |
| 31. I enjoy personal and mutual conversations with family members or friends. | 1 2 3 4 5 6 |
| 32. I don't have many people who want to listen when I need to talk. | 1 2 3 4 5 6 |
| 33. It seems to me that most other people have more friends than I do. | 1 2 3 4 5 6 |
| 34. People would describe me as a giving person, willing to share my time with others. | 1 2 3 4 5 6 |
| 35. I have not experienced many warm and trusting relationships with others. | 1 2 3 4 5 6 |
| 36. I know that I can trust my friends, and they know they can trust me. | 1 2 3 4 5 6 |
| 37. I live life one day at a time and don't really think about the future. | 1 2 3 4 5 6 |
| 38. I tend to focus on the present, because the future nearly always brings me problems. | 1 2 3 4 5 6 |
| 39. My daily activities often seem trivial and unimportant to me. | 1 2 3 4 5 6 |
| 40. I don't have a good sense of what it is I'm trying to accomplish in life. | 1 2 3 4 5 6 |
| 41. I used to set goals for myself, but that now seems like a waste of time. | 1 2 3 4 5 6 |
| 42. I enjoy making plans for the future and working to make them a reality. | 1 2 3 4 5 6 |
| 43. I am an active person in carrying out the plans I set for myself. | 1 2 3 4 5 6 |
| 44. Some people wander aimlessly through life, but I am not one of them. | 1 2 3 4 5 6 |
| 45. I sometimes feel as if I've done all there is to do in life. | 1 2 3 4 5 6 |
| 46. When I look at the story of my life, I am pleased with how things have turned out. | 1 2 3 4 5 6 |
| 47. In general, I feel confident and positive about myself. | 1 2 3 4 5 6 |
| 48. I feel like many of the people I know have gotten more out of life than I have. | 1 2 3 4 5 6 |
| 49. I like most aspects of my personality. | 1 2 3 4 5 6 |

| | | | | | | |
|---|---|---|---|---|---|---|
| 50. I made some mistakes in the past, but I feel that all in all everything has worked out for the best. | 1 | 2 | 3 | 4 | 5 | 6 |
| 51. In many ways, I feel disappointed about my achievements in life. | 1 | 2 | 3 | 4 | 5 | 6 |
| 52. My attitude about myself is probably not as positive as most people feel about themselves. | 1 | 2 | 3 | 4 | 5 | 6 |
| 53. The past had its ups and downs, but in general, I wouldn't want to change it. | 1 | 2 | 3 | 4 | 5 | 6 |
| 54. When I compare myself to friends and acquaintances, it makes me feel good about who I am. | 1 | 2 | 3 | 4 | 5 | 6 |

# APPENDIX G

# RESIDENT SATISFACTION INDEX

Please circle the number that corresponds to your attitude regarding the assisted living facility on your campus.

1=Never, 2=Rarely, 3=Sometimes, 4=Usually, 5=Always

| | | |
|---|---|---|
| 1. | Do you think the staff makes every effort to keep residents as healthy as possible? | 1 2 3 4 5 |
| 2. | Do you think that assisted living residents are receiving the medical attention that they need? | 1 2 3 4 5 |
| 3. | Do you think that there is a dependable staff in your assisted living? | 1 2 3 4 5 |
| 4. | Do you feel the nursing staff is kind and courteous? | 1 2 3 4 5 |
| 5. | Would you feel comfortable talking to the staff if you had health concerns? | 1 2 3 4 5 |
| 6. | Do you feel the cleaning of the apartments is done well? | 1 2 3 4 5 |
| 7. | Do you feel assisted living residents can participate in decisions about their own care? | 1 2 3 4 5 |
| 8. | Do you feel your assisted living is a well-maintained and clean facility? | 1 2 3 4 5 |
| 9. | Do you feel that assisted living residents can stay connected to the outside world? | 1 2 3 4 5 |
| 10. | Do you feel there is a lack of privacy in your assisted living? | 1 2 3 4 5 |
| 11. | Would you be satisfied with the floor plans in your assisted living? | 1 2 3 4 5 |
| 12. | Do you feel your assisted living is a home-like place to live? | 1 2 3 4 5 |
| 13. | Do you feel that residents receive too much help in your assisted living? | 1 2 3 4 5 |
| 14. | Do you feel that the staff is generally kind and caring? | 1 2 3 4 5 |
| 15. | Do you feel the people who serve the food are nice and courteous? | 1 2 3 4 5 |
| 16. | Do you feel assisted living residents have opportunities for creative/intellectual growth? | 1 2 3 4 5 |
| 17. | Do you feel that residents in your assisted living have their own identity? | 1 2 3 4 5 |
| 18. | Do you feel that assisted living staff speaks to residents courteously and appropriately? | 1 2 3 4 5 |
| 19. | Would you be satisfied with the personal assistance that assisted living provides? | 1 2 3 4 5 |
| 20. | Do you feel some staff treats residents in a rude way? | 1 2 3 4 5 |
| 21. | Do you feel the staff is slow to respond to requests? | 1 2 3 4 5 |
| 22. | Do you think you would like the social activities in assisted living (are they interesting)? | 1 2 3 4 5 |
| 23. | How often do you think you would attend social activities? | 1 2 3 4 5 |
| 24. | Do you feel you would have opportunities to participate in interesting activities? | 1 2 3 4 5 |

| | |
|---|---|
| 25. Do you think you would meet residents in assisted living who share your interests? | 1 2 3 4 5 |
| 26. Do you feel that you would have enough opportunities to participate in activities outside your assisted living? | 1 2 3 4 5 |
| 27. Do you think you would like the food in assisted living? | 1 2 3 4 5 |

# APPENDIX H

# DEBRIEFING STATEMENT

Thank you for participating in this study. The purpose of this study was to better understand perspectives of assisted living. We are particularly interested in the way in which independent living residents view an assisted living facility based on their sense of well-being, instrumental activities of daily living, coping skills, and perspectives on the specific assisted living facility on your campus. For example, does a strong sense of well-being make the prospect of moving to assisted living more palatable to someone, and does a high level of functioning in activities of daily living cause one to regard assisted living in a more positive light?

To date, there has been little research on perceptions of assisted living within a continuing care retirement community. The few studies available have focused on perspectives of skilled nursing facilities. This study will hopefully help us to better understand the decision process of independent living residents who are facing a move to assisted living from independent living.

Please contact Dr. Joanna Worthley at 909-880-5595 (jworthle@csusb.edu) or Brooke Crabb (becrabb@covenantretirement.org) if you have any questions or concerns about your participation in this study. Please do not reveal the nature of the study to other potential participants. It is anticipated that the group results of this study will be available by June 15, 2003.

Thank you again for your participation!

# APPENDIX I

## INFORMED CONSENT

The study in which you are about to participate is designed to investigate independent living residents' perceptions of assisted living. This study is being conducted by Brooke Crabb under the supervision of Dr. Joanna Worthley, Professor of Psychology. This study has been approved by the Department of Psychology Human Subjects Review Board, California State University, San Bernardino. The university requires that you give your consent before participating in this study.

You will be asked to respond to questions regarding your perceptions of assisted living, your sense of well-being, your coping strategies, and your instrumental activities of daily living. In addition, you will be asked to provide some demographic information. The questionnaire should take approximately 45-60 minutes to complete.

All of your responses will be confidential; the researcher will not share the data outside of the research project. However, you are being asked to supply your name and other contact information (name, telephone number, and apartment number) at the bottom of this form so that we can follow up questionnaires that have not been returned by the end of the week.

Once data collection is complete, the informed consent, which contains your personal information, will be permanently separated for the questionnaire, and will never again be used in connection with your responses. In addition, all data will be reported in group form only, without reference to individuals questionnaires. The formal results of this study will be available in Spring 2003.

Your participation in this study is completely voluntary. You are free to withdraw at any time without penalty. When you complete the task, you will receive a debriefing

statement describing the study in more detail. In order to ensure validity of the study, we ask you not to discuss this study with other residents.

If you have any questions regarding the study, please feel free to contact Brooke Crabb (becrabb@covenantretirement.org) or Dr. Joanna Worthley at (909) 880-5595 (jworthle@csusb.edu).

By placing an "X" in the box below, I acknowledge that I have been informed of, and that I understand the nature and purpose of this study, and I freely consent to participate.

Place an "X" here ☐ Today's date:_____

**Name**_____
**Telephone number**_____
**Apartment number**_____

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